

Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing current knowledge and uncertainties in decisions about gender-related treatment for transgender adolescents

While the use of puberty suppression has become widely accepted as part of health care for transgender adolescents and access to this treatment for minors has increased significantly (e.g., Mahfouda et al., 2017, 2019), progressively strong criticism has emerged (e.g., Laidlaw et al., 2019). Unfortunately, this criticism can have serious consequences for transgender adolescents, their families and their care providers as, for example, shown in the USA by proposals to legally prohibit the provision of gender-related medical care for minors in several states (Walch et al., 2021). Another such consequence is presently occurring in England, where a detransitioned patient and a parent brought a legal claim against the country's main (and only) youth transgender clinic of providing gender-related medical interventions when, they claim, giving informed consent is not possible prior to the age of majority at 18. In December 2020 the court gave a verdict in this case with the result that transgender adolescents can no longer start medical gender affirming treatment below the age of 16 unless a court order is obtained; the same procedure is also suggested for those aged 16 to 18 (High Court, Bell v Tavistock, 2020). The World Professional Association for Transgender Health (WPATH) and its European chapter the European Professional Association for Transgender Health (EPATH) expressed their strong disagreement with this verdict in a joint statement on December 18, 2020 (WPATH, 2020; EPATH, 2020). This statement was supported by the other regional chapters - including the US Professional Association for Transgender Health (USPATH), the Asian Professional Association for Transgender Health (AsiaPATH), the Canadian Professional Association for Transgender Health (CPATH), the

Australian Professional Association for Transgender Health (AusPATH) and the Professional Association for Transgender Health of Aotearoa (PATHA) (WPATH, 2020; EPATH, 2020).

The statement was prepared by the authors of the current editorial on behalf of the aforementioned organizations. The current paper is an extended version of that statement including the scientific evidence and references which the necessary brevity of such policy statements precludes. With this publication the authors wish to further detail their concern regarding the harm which may be caused by legal judgements which interfere with necessary medical treatment for transgender youth, undertaken in a shared decision-making process between patients and qualified clinicians, in precisely the same way as other necessary medical treatments for minors which are not transgender-related.

The case

On December 1, 2020, the High Court in London ruled (High Court, Bell vs. Tavistock, 2020) that “Children are highly unlikely to be able to consent to taking puberty blockers.” This was the outcome of a legal case against one of the oldest specialized youth gender clinics in the world, the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust working with the University College London Hospitals NHS Foundation Trust and the Leeds Teaching Hospitals NHS Trust (Dyer, 2020a). GIDS is the only provider of such care in the United Kingdom (UK). It was concluded that youth under age 16 generally cannot consent to the use of puberty blockers for gender dysphoria

since it is unlikely that they can understand the immediate and long-term consequences of the treatment; and further that patients who use puberty blockers inevitably move onto irreversible cross-sex hormone therapy and therefore also have to foresee the consequences of such treatment in order to be able to consent to puberty suppression. The far-reaching result of the judgment is that all applicants for gender-related medical intervention in the UK under the age of 16 will first have to go to court for authorization, and if they are denied, will not have access to such treatment (Dyer, 2020b). The court further suggested that for those between 16 and 18 (18 being the age of majority in the UK) “it would be appropriate for clinicians to involve the court in any case where there may be any doubt as to whether the long-term best interests of a 16 or 17-year-old would be served by the clinical interventions at issue in this case.”

After years wherein access to medical care for transgender youth has gradually become much more available and a concomitant expansion of clinical experience and outcome research is seen, the current court order is a retrograde step which results in severe barriers to care for transgender youth in the UK. EPATH and WPATH have serious concerns about this ruling and wish to state that although treatment for young transgender adolescents involves uncertainties, as is the case in many fields involving young people, studies demonstrate the clear benefits of appropriate medical treatment which includes puberty blockers for many young people. Withholding such treatment may therefore be harmful with potential life-long psychological, social, and medical consequences, as summarized below.

Immediate and long-term consequences of puberty blockers

The provision of puberty suppression as a reversible medical intervention was introduced into clinical care in the late 1990s by Dutch clinicians Cohen-Kettenis et al. (2008). The aim of puberty suppression was to prevent the psychological suffering which stems from distressing physical changes when puberty starts, and to allow the adolescent time to carefully consider whether or

not to pursue further transition. Treatment of transgender adolescents involving gender affirming medical interventions (puberty suppression and subsequent gender affirming sex hormones) has become the most widely accepted clinical approach in specialized transgender clinics around the world and is accepted best practice amongst specialist clinicians. For this reason, it forms part of the two main international guidelines in the field: the WPATH’s *Standards of Care* as well as the Endocrine Society’s *Clinical Practice Guidelines* (Coleman et al., 2012; Hembree et al., 2017). Indeed, no professional association with expertise in the field has opposed the use of these medical interventions; instead, there is professional consensus - based on clinical experience and empirical evidence that medical interventions for carefully selected individuals are helpful and potentially lifesaving for transgender youth before the age of 16 (Turban et al., 2020). The relevant professional associations supporting these guidelines as co-sponsors include the European Society of Pediatric Endocrinology, the European Society of Endocrinology, the Pediatric Endocrine Society, the American Association of Clinical Endocrinologists, and WPATH for the Endocrine Society’s *Clinical Practice Guidelines*. Further statements and consensus papers also support these interventions such as the American Academy of Pediatrics (Rafferty & Committee on Psychosocial Aspects of Child and Family Health, 2018) and the European Society of Sexual Medicine (T’Sjoen et al., 2020). The American Psychological Association Task Force on Gender Identity and Gender Variance Report (APA, 2009) also recognized the medical necessity and benefits of gender-transition treatments for youth who are evaluated carefully. These treatments are therefore not typically viewed by professionals with expertise in this area as radical or ancillary treatments but, when administered by a trained provider following thorough assessment, as important and commonly accepted practices which support the well-being of transgender youth.

In contrast, the High Court in London judged the evidence base for gender-related medical treatment for children and adolescents to be “highly uncertain.” Both within and outside of the field of transgender health, the relative

paucity of scientific evidence is acknowledged (e.g., Byng et al., 2018; Pang et al., 2019) and all involved agree there is a need for further research (Chen et al., 2020a; Olson-Kennedy et al., 2016). An explanation for the lack of studies may be that finding financial resources to conduct long term longitudinal clinical follow up studies is challenging. However, at present, various studies, including some relatively large scale prospective longitudinal studies, are in progress in different parts of the world (Olson-Kennedy et al., 2019; Reardon, 2016; Tollit et al., 2019). Importantly, the first such longer term longitudinal cohort follow-up research from the Netherlands, where this approach was developed, shows promising findings on the effectiveness (de Vries et al., 2011, 2014). Shorter term follow-up research in the UK also shows improved psychological functioning after 6 months of puberty suppression (Costa et al., 2015). To date, these studies have provided the main evidence for the effectiveness of puberty suppression.

Recently, two new longitudinal studies from the US have replicated the decline in depression and anxiety scores and improved quality of life after approximately 1 or 1.5 year of puberty suppression and/or hormones (Achille et al., 2020; Kuper et al., 2020) as was previously found by de Vries et al. (2014). One new cross-sectional study from the Netherlands also showed decreased emotional and behavioral problems in those on puberty suppression compared to those who hadn't started treatment yet (van der Miesen et al., 2020). Just one other recent longitudinal published study of a sample of 44 transgender young adolescents (aged 12–15 years) using puberty blockers did not show an improvement in psychological functioning over a three-year period, although there was no decline in psychological functioning either, and adolescents were satisfied with their treatment (Carmichael et al., 2021). Of further note, a U.S. National Institutes of Health-funded long-term study using a baseline mental health evaluation found that youth presenting for medical treatment of gender dysphoria at early vs. late stages of puberty “endorsed lower rates of depression, anxiety, and suicidality and higher body esteem and life satisfaction” (Chen et al., 2020b). Edwards-Leeper et al. (2017)

and Sobrara et al. (2020) also found that when youth first present for treatment at an older age they experience higher levels of distress compared to their counterparts who request treatment at an earlier age. Although the findings of these cross-sectional studies need careful consideration (de Vries, 2020), they highlight the possible benefits of access to appropriate medical care earlier in life rather than later (Chen et al., 2020b). Alongside other factors such as family and social support, the prevention of an unwanted puberty with the associated physical changes (the development of breasts for an affirmed boy or beard and deep voice for an affirmed girl) is likely to have contributed to the alleviation of psychological distress and well-being and a healthy psychological development. A legal judgment that, in most cases, will result in youth not having access to medical interventions which act to reduce these health concerns, or only having access after a significant delay, leaves little doubt that many youth will suffer chronically, significantly and unnecessarily. In addition, it may lead to collateral negative effects such as academic decline, social withdrawal, poor mental health and occupational dysfunction.

Do puberty blockers lead to further gender affirming treatment?

Gender affirming medical interventions for adolescents are usually offered in a step-wise approach from reversible to irreversible treatments. Starting with hormone blockers such as Gonadotropin Hormone Releasing agonists (GnRHa), whose effects on pubertal development are considered reversible according to the current literature (Panagiotakopoulos et al., 2020), young people are provided with ample time to explore their gender. If desired, this can be followed by a reversion to their birth assigned gender role. Whereas for those who wish to continue with their physical transition and who have been carefully evaluated by qualified clinicians, partially reversible hormonal therapy, and finally irreversible surgeries are options; it is not the case that one stage invariably leads to the next.

So far, the follow-up studies after puberty suppression from the Netherlands show that the rate

of adolescents that stop the reversible blockers because they no longer wish to transition is very low; 1.9% (Wiepjes et al., 2018) and 3.5% (Brik et al., 2020) in two respective studies. This is not surprising since treatment is only started in those for whom gender incongruence is thought to be very likely to last into adulthood. However, this does not mean that, as the UK court ruling erroneously suggests, adolescents ‘automatically’ go on to gender affirming hormone treatment after puberty suppression; nor does it mean that puberty suppression somehow *causes* adolescents to pursue further treatment. Hormone treatment is a carefully considered next step for which adolescents (and their parents) provide separate informed consent after having received information about the effects, limitations, and potential side effects of this treatment, with particular emphasis on fertility. By the time adolescents are eligible for this treatment they are usually around the age of 16 years (and sometimes younger; Hembree et al., 2017) and better able to foresee the consequences of this partially irreversible step. It is not reasonable to require adolescents to already foresee and weigh up all consequences of cross-sex hormone treatment at the time they start puberty suppression as the High Court suggests, since each step is clinically distinct.

The High Court inferred from the low detransition rates not that the young people were being appropriately selected through the stringent clinical assessment process employed, but rather that puberty suppression was the first part of a treatment which would inevitably and causatively lead to affirming hormones and surgeries with lifelong consequences for fertility, relationships, and gender identity. Therefore, the High Court concluded that the younger adolescents must not only make a decision on puberty blockers, with reversible effects, but also on the subsequent treatment with irreversible effects. However, we do not agree. Our reading of the research findings is one of reassurance that careful assessment before starting medical treatment leads to provision of puberty blockers only to those adolescents with a high likelihood of lasting gender incongruence into adulthood. The fact that they continue with hormonal care when they are older validates a stability in gender identity

experienced over time; this indicates that these youth were able to make informed choices at an earlier age without regrets in later adolescence and early adulthood.

The recent increase of gender diverse adolescents presenting to specialized transgender care clinics for medical interventions such as puberty blockers has also raised questions. It has been suggested that new categories of patients are seeking care with possibly lower diagnostic thresholds (Landén, 2019). However, a study from the Amsterdam transgender clinic that investigated trends over time by comparing certain key characteristics from earlier to recent applicants, showed no changes in intensity of gender dysphoria, psychological functioning, and age, between 2000 and 2016 (Arnoldussen et al., 2020). The only change was a shift in gender ratio in favor of birth assigned females. Although again these results merit further study, they also show that the recently observed exponential increase in referrals might reflect a societal shift in which people feel more able to come forward for help, rather than presenting with less intense gender dysphoria (for which medical treatment might not be necessary) or more psychological problems (that interfere with assessment and make it likely that treatment is less effective).

The harm of not providing puberty blockers

Our deep concern is that the High Court overlooked not only the immediate positive effects of puberty suppression, which have resulted in decreased psychological suffering and a healthier adolescent development; but also the lifelong benefits of having a physical appearance which is congruent with one's gender identity (e.g., no or less breast development and less feminine body shape in an affirmed male and no low voice, Adam's apple, or masculine facial features in an affirmed female). Many transgender adults wish they could have had treatment in adolescence (Turban et al., 2020). This is a vital point, where not only research findings, as well as any lacuna within the available evidence, should be considered. A medical ethics approach is also relevant, one that appreciates gender diversity as an expected aspect of human diversity, rather than

something to be avoided at all costs, including the cost of significant psychological decompensation of gender diverse individuals in the absence of affirmative treatments. It is important to realize that allowing puberty to progress in adolescents who experience gender incongruence is not a neutral act and may have lifelong harmful effects for a transgender young person such as stigmatization, personal physical discomfort, difficulty with sexual function, and difficulty with social integration (Giordano, 2008; Giordano & Holm, 2020; Kreukels & Cohen-Kettenis, 2011). In addition, individuals may have to endure expensive and invasive medical procedures when they are older, such as hair removal or feminizing facial surgery for women, and mastectomy for men, interventions that can be avoided by the use of puberty blockers. Thus, while medical care for transgender adolescents deserves further research and evidence (as with many fields), withholding such treatment is not an innocuous option and is likely to cause harm.

The age of consent

As noted in the case *Bell vs. Tavistock and Portman NHS Foundation Trust* (High Court, 2020), "The sole legal issue in the case is the circumstances in which a child or young person may be competent to give valid consent to treatment in law and the process by which consent to the treatment is obtained." Even when they do not yet have the legal right to give their own consent to treatment, research has demonstrated that many minors possess the cognitive and emotional abilities to understand the consequences of their decisions, including decisions concerning health care. In fact, minors as young as 12 years of age frequently possess this ability (Hein et al., 2015; Redding, 1993). A recent study using a standardized measure (MacCAT-T), determined that 90% of the transgender adolescents about to receive puberty suppression are assessed to be competent to consent (Vrouenraets et al., submitted). This study also showed that in cases where there was doubt about the young person's competence, the decision to start puberty suppression depended more heavily on the parents' informed consent, although never to consent to

a treatment which young persons themselves, did not want. In all cases, unless this is not in the best interest of the adolescent, parents are involved in the medical decision-making process. The UK court argued that adolescents cannot fully foresee the impact that possible consequences of treatment such as infertility and altered sexual function may have on their adult life. Most parents, however, are fully aware of this, and can nonetheless support treatment of their children because they see that the benefits of the treatment outweigh any potential harm. Further, in this study, in the cases where young adolescents were not considered competent, the time that puberty suppression was provided was explicitly used to ensure that the adolescent developed competence in order to make fully informed decisions regarding subsequent treatments which have more irreversible effects (Vrouenraets et al., submitted). When prescribing puberty blockers and gender affirming hormones before the age of 16, the same procedures are followed as for other prescribed medication or treatment that minors receive with informed consent given by parents acting as proxies, and youth giving informed assent to the best of their abilities. The assumption that medical interventions for transgender youth are less necessary than for other areas of medical pediatric practice is misguided and not supported by the evidence of the mental health burden carried by untreated transgender youth. In pediatric care, there are many instances in which parents act as proxies when their children are unable to engage in informed consent, such as when children are too young, too impaired by their medical condition, or are psychiatrically or cognitively unable to consent. In those cases, it is commonly understood that parents can make decisions regarding the best interest of their children and sometimes consent processes can be adapted so that youth can assent to the best of their abilities (Shumer & Tishelman, 2015).

Finally, given the extensive diagnostic and counseling work that precedes decisions around gender affirming medical treatment to minors, we are convinced that the determination of the ability of a particular adolescent to give consent should be made by a competent health provider who has

evaluated the adolescent, and not by a court of law. Current guidelines already recommend that this competence is assessed by a specialized health professional prior to the start of treatment (Coleman et al., 2012; Hembree et al., 2017).

Conclusion

WPATH, EPATH, USPATH, AsiaPATH, CPATH, AusPATH, and PATHA recommend that capacity to consent is evaluated on a case-by-case basis by the treating clinician and not by a court of law. We do not agree that transgender healthcare is so different in kind to that provided to cisgender people as to warrant separate legal provision. We consider puberty blocking treatment and treatment with gender affirming sex hormones as two separate treatment steps, each requiring informed consent at the time such treatment is to be started.

We support the provision of healthcare to gender diverse people in a timely manner such that they can live their best lives. We are gravely concerned that the UK ruling will have a significantly adverse impact upon gender diverse youth and their families by imposing barriers to care that are costly, needlessly intimidating, and inherently discriminatory.

Disclosure

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